State of Connecticut
Office of Health Care Access
Letter of Intent/Waiver Form
Form 2030

All Applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	Christian Medical Fellowship	
Doing Business As	Christian medical Fellowship	
Name of Parent Corporation	N/A	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	504 Main St Farmington CT 06032	
Applicant type (e.g., profit/non-profit)	Non-profit	
Contact person, including title or position	Dr. Peter Schnatz, CEO	
Contact person's street mailing address	CMF 504 Main St Farmington CT 06032	Hartford Hospital 80 Seymour St Hartford CT 06102
Contact person's phone #, fax # and e-mail address	860-674-0698 860-674-2740 PSchnat@harthosp.org	860-545-4054

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Christian Medical Fellowship Medical Clinic

b. Type of Proposal, please check all that apply:

☑ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

☑ New (F, S, Fnc) ☐ Replacement ☐ Additional (F, S, Fnc)

☐ Expansion (F, S, Fnc) ☐ Relocation ☐ Service Termination

☐ Bed Addition` ☐ Bed Reduction ☐ Change in Ownership/Control

☐ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

☐ Project expenditure/cost cost greater than $ 1,000,000

N/A ☐ Equipment Acquisition greater than $ 400,000

☐ New ☐ Replacement ☐ Major Medical

☐ Imaging ☐ Linear Accelerator

N/A ☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $1,000,000

c. Location of proposal (Town including street address): 48 Main Street Hartford CT.

d. List all the municipalities this project is intended to serve: Hartford

e. Estimated starting date for the project: Oct 1, 2006

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f. Type of project: 16/25 **(Fill in the appropriate number(s) from page 7 of this form)**

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed
N/A				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure: $ _____

b. Please provide the following breakdown as appropriate:

Construction/Renovations	$ 18,000.
Medical Equipment (Purchase)	10,000.
Imaging Equipment (Purchase)	0
Non-Medical Equipment (Purchase)	18,500
Sales Tax	0
Delivery & Installation	300
Total Capital Expenditure	$ 46,800.
Fair Market Value of Leased Equipment	0
Total Capital Cost	$ 46,800.

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
N/A				

Note: Provide a copy of the contract with the vendor for major medical/imaging equipment.

c. Type of financing or funding source (more than one can be checked):

☐ Applicant's Equity	☐ Lease Financing	☑ Conventional Loan
☑ Charitable Contributions	☐ CHEFA Financing	☑ Grant Funding
☐ Funded Depreciation	☐ Other (specify): _____	

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Who is the current population served and who is the target population to be served?
4. Identify any unmet need and how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. What is the effect of this project on the health care delivery system in the State of Connecticut?
7. Who will be responsible for providing the service?
8. Who are the payers of this service?

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT

I may be eligible for a waiver from the Certificate of Need process because of the following: (Please check all that apply)

n/A

☐ This request is for Replacement Equipment.

- ☐ The original equipment was authorized by the Commission/OHCA in Docket Number: _____.
- ☐ The cost of the equipment is not to exceed $2,000,000.
- ☐ The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit for Section V only.

Christian Medical Fellowship Health Clinic

1&2: Christian Medical fellowship is a 501-C-3 nonprofit organization that seeks to provide, at an affordable rate to patients, medical services to uninsured and low income residents of Hartford, CT. The range of medical services include primary care, minor surgical procedures, referrals to specialists and limited laboratory services; in addition to some prescriptions medications that will be at no cost to patients.

3&4: Services are provided primarily to uninsured and low income residents of Hartford, CT; as there is a growing population of over 40,000 patients of uninsured and low income residents in Hartford that can benefit greatly from this service.

5&6: There are not any similar services in the proposed area. This project will improve the efficacy and delivery of health care system in Connecticut by including more people, and providing first class services and preventive medical services to a city with a growing population of uninsured and low income residents.

7&8: A volunteer team of Board certified internists, Ob/GYN's, Family practitioners, Emergency Medicine Physicians, and other Specialists will form the core consulting team. In addition, we will have volunteer nurses, patient care assistants and anxillary support. These volunteers along with others will provide services through several one day sessions per week. A fundraising/Development committee has been formed, that will enlist the support of:

Hartford Hospital and other medical facilities.
Local business/professional banking community
Local/regional fraternal and religious organizations
Private donations
Foundations

AFFIDAVIT

Applicant: Christian Medical Fellowship

Project Title: Christian Medical Fellowship Medical Clinic

I, Peter F. Schnatz, DO, FACOG CEO/Chairman CMF
(Name) (Position – CEO or CFO)

of Christian Medical Fellowship being duly sworn, depose and state that the information provided in this CON Letter of Intent/Waiver Form (2030) is true and accurate to the best of my knowledge, and that Christian Medical Fellowship Medical Clinic complies with the appropriate and
(Facility Name)

applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature 6-26-06
Date

Subscribed and sworn to before me on June 26th, 2006

Notary Public/Commissioner of Superior Court

My commission expires: October 31st, 2006

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

July 6, 2006

Peter Schnatz
CEO
Christian Medical Fellowship
504 Main Street
Farmington, CT 06032

RE: Certificate of Need Application Forms, Docket Number 06-30784-CON
Christian Medical Fellowship
Establish Christian Medical Fellowship Medical Clinic

Dear Schnatz:

Enclosed are the application forms for Christian Medical Fellowship's Certificate of Need ("CON") proposal for the Establish Christian Medical Fellowship Medical Clinic with an associated capital expenditure of $46,800. According to the parameters stated in Section 19a-638 of the Connecticut General Statutes the CON application may be filed between August 27, 2006, and October 26, 2006.

When submitting your CON Application, please paginate and date each page contained in your submission. In addition, please submit one (1) original and five hard copies; as well as a scanned copy of the complete Application, including all attachments, on CD or Diskette. OHCA requests a copy of the submission be in MS Word format and the scanned copy be in Adobe format. Please submit the Financial Attachment and other data as appropriate in MS Excel format.

The analyst assigned to the CON application is Paolo Fiducia. Please feel free to contact him/her at (860) 418-7001, if you have any questions.

Sincerely,

Kimberly Martone
Certificate of Need Supervisor

Enclosures

State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, Not Applicable may be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than August 27, 2006, and may be submitted no later than October 26, 2006. The Analyst assigned to your application is Paolo Fiducia and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 06-30784-CON

Applicant(s) Name: Christian Medical Fellowship

Contact Person: Peter Schnatz
Contact Title: CEO
Christian Medical Fellowship
Contact Address: 504 Main Street
Farmington, CT 06032

Project Location: Hartford

Project Name: Establish Christian Medical Fellowship Medical Clinic

Type proposal: Section 19a-638, C.G.S.

Est. Capital Expenditure: $46,800

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposed expansion or new service will augment or replace? Please list.

Augment: _____

_____

Replace: _____

_____

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

If "No" is checked, please provide an explanation.

4. Clear Public Need

A. Explain how it was determined there was a need for the proposal in your service area.

i) Provide the following information:
a) Primary and secondary service area towns
b) The population to be served, including the number of individuals to receive the proposed service(s). Include demographic Information, as appropriate. Provide the # of referrals for the proposed service for the past year.
c) Scheduling backlogs in service area
d) Travel distance from proposed site to service area towns
e) Hours of operation of existing/proposed service

ii) What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

iii) Provide the units of service projected for the first three years of operation of the proposed service. **Include the derivation/calculation.**

iv) Provide the information as outlined in the following table concerning the existing providers' (in the Applicant(s) PSA & SSA) current operations:

Primary Service Area:

Name of Provider	Similar Services Provided? (Y/N)	Affiliated Physicians

Secondary Service Area:

Name of Provider	Similar Services Provided? (Y/N)	Affiliated Physicians

B. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify) _____

If you checked other than None of the above, please provide an explanation.

C. Provide copies of any of the following plans, studies or reports related to your proposal:

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify) _____

☐ None: *explain* why no reports, studies or market share analysis was undertaken related to the proposal:

_____
_____
_____
_____

5. Quality Measures

A. If the proposal is for a new technology or procedure, have all appropriate agencies approved the proposed procedure (e.g., FDA etc.)?

☐ Yes ☐ No ☐ Not Applicable

If "No", please provide an explanation.

B. Check off all the Standard of Practice Guidelines that will be utilized by the Applicant for the proposed service. Please submit the most recent copy of each report related to the proposal:

☐ American College of Cardiology	☐ National Committee for Quality Assurance	☐ Public Health Code & Federal Corollary
☐ National Association of Child Bearing Centers	☐ American College of Obstetricians & Gynecologists	☐ American College of Surgeons
☐ Report of the Inter-Council for Radiation Oncology	☐ American College of Radiology	☐ Substance Society Abuse and Mental Health Services Administration

☐Other: Specify _____

C. Describe in detail how the Applicant plans to meet the each of the guidelines checked off above.

D. Submit a list of **all** key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, nurses,

therapists, counselors, etc., related to the proposal and a copy of their Curriculum Vitae.

Note: For physicians, please provide a list of hospitals where the physicians have admitting privileges.

E. Provide a copy of the most recent inspection reports and/or certificate for your facility:

☐ DPH ☐ JCAHO

☐ Fire Marshall Report ☐ Other States Health Dept. Reports (new out-of-state providers)

☐ AAAHC ☐ AAAASF

☐ Other: _____

Note: Above referenced acronyms are defined below. [1]

F. Provide a copy of the following (as applicable):

☐ A copy of the related Quality Assurance plan

☐ Protocols for service (new service only)

☐ Patient Selection Criteria/Intake form

6. Improvements to Productivity and Containment of Costs

In the past year has your facility undertaken any of the following activities to improve productivity and contain costs?

☐ Energy conservation ☐ Group purchasing

☐ Reengineering ☐ None of the above

☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)

☐ Other (identify)_____

7. Miscellaneous

[1] DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

A. Will this proposal result in new (or a change to) your teaching or research responsibilities?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

B. Are there any characteristics of your patient/physician mix that makes your proposal unique?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

C. Provide the following licensing information:

i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.

ii) The DPH licensure category you are seeking.

iii) If not applicable, please explain why.

8. Financial Information

A. Type of ownership: (Please check off all that apply)

☐ Corporation (Inc.) ☐ Limited Liability Company (LLC)

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

B. Provide the following financial information:

i) Please submit the Applicant's audited financial statements for the most recently completed fiscal year. If the Applicant has no audited financial statements, please submit a compilation report or an unaudited Balance Sheet and Statement of Operations for the most recently completed fiscal year. These statements should be externally prepared and submitted on the preparer's letterhead.

ii) Identify the entity that will be billing for the proposed service.

9. Major Cost Components/Total Capital Expenditure

Submit a final version of all capital expenditures/costs as follows:

Medical Equipment (Purchase)	
Major Medical Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	
Medical Equipment (Lease (FMV))	
Major Medical Equipment (Lease (FMV)	
Non-Medical Equipment (Lease (FMV))*	
Fair Market Value of Space – (Capital Leases Only)	
Total Capital Cost	
Capitalized Financing Costs (Informational Purpose Only)	
Total Capital Expenditure with Cap. Fin. Costs	

* Provide an itemized list of all non-medical equipment.

10. Construction Information

A. Provide a detailed description of the proposed new construction/renovation including the related gross square feet of new construction/renovation.

B. Provide all schematic drawings related to the project that are available, including existing and proposed floor plans.

C. Provide the following breakdown of the new construction/renovation costs:

Item Designations	New Construction	Renovation	Total Cost
Total Building Work Costs			
Total Site Work Costs			
Total Off-Site Work Costs			
Total Arch. & Eng. Costs			
Total Contingency Costs			
Inflation Adjustment			

Other (Specify)_____			
Total Construction/Renov. Cost			

D. Explain how the proposed new construction or renovations will affect the delivery of patient care.

E. Provide the following information regarding the schedule for new construction/ renovation:

Construction Commencement Date	
Construction Completion Date	
DPH Licensure Date	
Commencement of Operations Date	

11. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicant's equity:

Source and amount:

Operating Funds Source/Entity Name Available Funds	$_____ _____
Contributions	$_____
Funded depreciation	$_____
Other	$_____

☐ Grant:

Amount of grant	
Funding institution/ entity	

☐ Conventional loan or
☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	

CON Proposed debt financing	
Interest rate	%
Monthly payment	
Term	Years
Debt service reserve fund	

☐ Lease financing or
☐ CHEFA Easy Lease Financing:

Current CHEFA Leases	
CON Proposed lease financing	
Fair market value of leased assets at lease inception	
Interest rate	%
Monthly payment	
Term	Years

☐ Other financing alternatives:

Amount	
Source (e.g., donated assets, etc.)	

B. Please provide copies of the following, if applicable:
   i. Letter of interest from the lending institution,
   ii. Letter of interest from CHEFA,
   iii. Amortization schedule (if not level amortization payments),
   iv. Lease agreement.

12. Revenue, Expense and Volume Projections

A.1. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format:

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*	%	%	%	%
Medicaid* (includes other medical				

assistance)				
CHAMPUS and TriCare				
Total Government Payers				
Commercial Insurers*				
Uninsured				
Workers Compensation				
Total Non-Government Payers				
Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

A.2. Please describe the impact of the proposal on the interests of consumers of health care services and the payers of such services.

B. Does the Applicant(s) have Tax Exempt Status? ☐ Yes ☐ No

C. Provide the following for the financial and statistical projections:

i) A summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the CON project. **See attached.** Please note that the actual results for the fiscal year reported in the first column must agree with the Applicant's audited financial statements.

ii) The assumptions utilized in developing the projections (e.g., FTE's by position, volume statistics, other expenses, revenue and expense % increases, project commencement of operation date, etc.).

iii) An explanation for any projected incremental losses from operations contained in the financial projections that result from the implementation and operation of the CON proposal.

iv) Provide a copy of the rate schedule for the proposed service.

v) Describe how this proposal is cost effective.

GENERAL AFFIDAVIT

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the (Facility Name) said facility complies with the appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

13. B (i). Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and if applicable, volume statistics without, incremental to and with the proposal in the following reporting format:

Total Facility:	FY	FY	FY	FY	FY	FY	FY	FY	FY	FY
Description	**Actual Results**	**Projected W/out Project**	**Projected Incremental**	**Projected With Project**	**Projected W/out Project**	**Projected Incremental**	**Projected With Project**	**Projected W/out Project**	**Projected Incremental**	**Projected With Project**
Revenue from Operations				$0			$0			$0
Non-Operating Revenue				$0			$0			$0
Total Revenue:	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Operating Expenses				$0			$0			$0
Revenue Over/(Under) Expense	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

*Volume Statistics:

*Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.